STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155261	A. BUILDING 01 B. WING	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSBURG HEALTH CARE	1609 LAFAYETTE ROAD CRAWFORDSVILLE, IN47933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/25/11 Facility Number: 000162 Provider Number: 155261 AIM Number: 100284300 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Williamsburg Health Care was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke	K0000	Submission of this plan of correction shall not constitute or be construed as an admission by Williamsburg Health Care that the allegations contained in this survey report are accurate or reflect accurately the provision of service to the residents of Williamsburg Health Care.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	detection in the corridors and spaces open to the corridors. The facility has a capacity for 116 and had a census of 71 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 04/01/11. The facility was found not in compliance with the aforementioned requirements as evidenced by:			

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K0029 SS=E	Based on observation and interview, the facility failed to provide an automatic closer for the door providing access to 1 of 8 hazardous areas such as a combustible materials storage room larger than 50 square feet. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 29 residents in the Desk 1 wing. Findings include: Based on observation with the administrator on 03/25/11 at 2:45 p.m., the door separating the ten by twelve foot clean linen storage room near physical therapy had no self closing device. The administrator said at the time of observation, she didn't realize the door was required to self close. 3.1-19(b)	K0029	**K029** I. No residents were affected by the deficient practice. II. An automatic closer was placed on the door. No other spaces were identified as being in need of automatic closers. Photographs of the automatic closer placed on the door to the room referenced in the 2567 are provided in Exhibit 1 and Exhibit 2. III. The administrator or designee will monitor rooms requiring the presence of automatic closers to ensure that automatic closers are present. The results of the monitoring will be reported in the next two quality assurance committee meetings. IV. As the evidence of the placement of the automatic closer is provided in Exhibit 1 and Exhibit 2, Williamsburg Health Care is requesting paper compliance for tag K029.	03/31/2011

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K0052 SS=F	Based on record review and interview, the facility failed to ensure documentation for the annual testing of 1 of 1 fire alarm system's components and devices such as smoke detectors, heat sensors and fire alarm pull stations was complete. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors, heat sensors, fire alarm pull stations, and fire alarm control equipment be tested annually. The inspection should include locations and serial numbers, the test/inspection done and whether each device passed or failed. This deficient practice could affect all occupants. Findings include: Based on review of the facility's Periodic Fire Alarm Inspection and Test Report dated 02/25/11 with the administrator at 11:45 a.m. on 03/25/11, item B noted 42 smoke detectors were installed and 22 smoke detectors were function tested on the test date. Two additional pages dated 02/25/11 listed 40 smoke detectors and "pass" for each. The administrator	K0052	**K052** I. No residents were affected by the deficient practice.II. The monitoring company was reminded of the importance of providing an accurate listing of all pull stations and smoke detectors upon each annual test. The monitoring company tested all 12 pull stations and 43 smoke detectors on 4/08/11. The results of the test are provided in Exhibit 3. III. In an attempt to ensure this deficient practice does not recur, the administrator or designee will monitor each year for completion, accuracy, consistency, and provision of a list of all pull stations and smoke detectors tested.IV. As the results of the test are provided in Exhibit 3, Williamsburg Health Care requests paper compliance on tag K052.	04/08/2011

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	could not explain why the fire alarm report listed 42 smoke detectors and the list of devices tested included 40. In addition, she could not verify whether or not 40 or 22 smoke detectors were tested. She was certain no smoke detectors had been removed but did not know the total number in the facility. 3-1.19(b)			

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K0130 SS=E	Based on record review, observation and interview; the facility failed to maintain 2 of 2 rolling fire doors in accordance with NFPA 80, 1999 Edition, Standard for Fire Doors and Fire Windows 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors shall be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice affects staff, visitors and and 23 in the Desk 3 wing. Findings include: Based on observation with the administrator on 03/25/11 at 1:10 p.m. vertical rolling fire doors protected two service window openings between the kitchen service corridor adjacent to the Desk 3 wing. A review of fire equipment inspection and testing reports on 03/25/11 at 11:30	K0130	**K130** I. No residents were affected by the deficient practice. II. A test was performed on the rolling fire doors on 4/14/11. The results of the test are provided in Exhibit 4. III. In an attempt to ensure this deficient practice does not recur, the administrator or designee will monitor each year for completion and provision of a test on the rolling fire doors. IV. As the results of the test are provided in Exhibit 4, Williamsburg Health Care is requesting paper compliance on tag K130.	04/14/2011

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	a.m. did not include a report of testing for the rolling fire doors. An interview with the administrator at the time of record review, indicated no inspection had been done. 3.1-19(b)			

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K0144 SS=F	Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: During a tour of the facility with	K0144	**K144** I. No residents were affected by the deficient practice. II. The emergency stop button was installed on 3/31/11. A photograph of the Emergency Stop Button for the generator is provided in Exhibit 5. III. As evidence of the placement of the Emergency Stop Button is provided in Exhibit 5, Williamsburg Health Care is requesting paper compliance on tag K144.	03/31/2011

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	the administrator on 03/25/11 between 12:40 p.m. and 3:15 p.m., a remote emergency stop for the emergency generator was not observed. Based on interview on 03/25/11 at 3:20 p.m. with the administrator, she did not think the emergency generator, installed prior to 2003, was 100 horsepower. There was no documentation to provide evidence of the actual horsepower of the generator. She said plans were made for the installation of a remote emergency stop, but there was no supporting documentation and the installation date had not been set. 3.1-19(b)			